

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/22/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 06/21/2011	
NAME OF PROVIDER OR SUPPLIER BELL OAKS TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN47630			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
R0000	<p>This visit was for a post survey revisit [PSR] to the state residential licensure survey, completed on 3/4/11. This visit was for the post survey revisit [PSR] to the PSR completed on 02/16/11 to the unrelated deficiencies cited during the investigation of complaint IN00084710 completed on 01/13/11.</p> <p>Survey dates: June 15, 16, 17, 20, 21, 2011</p> <p>Facility number: 004903 Provider number: 004903 AIM number: N/A</p>			R0000	<p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Survey team: Amy Winger, RN, TC Diane Hancock, RN Martha Saull, RN [June 20, 2011] Census bed type: Residential=41 Total= 41 Census payor type: Other= 41 Total= 41 Sample: 5 Supplemental sample: 20 These state residential findings are in accordance with 410 IAC 16.2-5. Quality review completed 6/27/11 Cathy Emswiller RN						